If you look at the long list of papers he’s published during his career, you might question whether Timothy J. Wilt, M.D., M.P.H., has had a focus. You’ll see articles about such diverse topics as trazadone for erectile dysfunction, fish oil for plasma cholesterol and botulin toxin for urinary incontinence. And there are multiple titles on heart disease; knee arthroplasty; breast, colorectal and prostate cancer; and myriad other maladies. The broad range of subjects belies the fact that Wilt has indeed had a goal: to identify clinical practices that work.

Wilt started on that quest not long after completing his residency in internal medicine at the University of Minnesota in the late 1980s. Researchers then were just beginning to systematically analyze published research in order to identify the evidence for certain clinical practices. The approach would come to be called “evidence-based medicine” in the 1990s.

In 1987, he took a position at the Minneapolis Veterans Affairs Medical Center, where his first section chief, Richard Lofgren, M.D., encouraged him to think critically. At the time, the VA was just starting to introduce clinical performance measures, and that got Wilt asking questions about why doctors were doing certain things. He read an article that questioned the value of surgery for patients with early prostate cancer, and he read others about the overdiagnosis of the disease. Those things prompted him to propose that the VA fund a study on prostate cancer treatment.

Wilt was then asked to lead a Cochrane Review Group on prostate and urological diseases. “I was doing this prostate cancer treatment trial, and the director of health services research at the VA was looking to kind of get into this new methodology of doing systematic reviews and called me up and said, ‘Would I be interested and did I think I could do it?’ I said, ‘Yes and yes.’”

Wilt had gotten in on the ground floor of the evidence-based medicine movement. “To be honest, it was serendipity,” he says. In 2002, he became co-director with Robert Kane, M.D., of the Minnesota Evidence-Based Practice Center, a collaboration between the VA and University of Minnesota funded by the Agency for Healthcare Research and Quality. He took the helm of the Minneapolis VA Evidence-Synthesis Program, and over the years has served on committees that turn that evidence into guidelines. He is a member of the VA Preventive Medicine Advisory Committee and the American College of Physicians Clinical Guideline Committee and a former member of the U.S. Preventive Services Task Force.

In 2012, Wilt was thrust into the national spotlight when his article on the prostate cancer trial he launched in the 1990s, the Prostate Cancer Intervention Versus Observation Trial (PIVOT), was published in the New England Journal of Medicine. That study demonstrated a lack of benefit and increased harm from radical prostatectomy for most men, causing urologists and primary care physicians around the world to change their practices.

In March, Wilt received the 2014 VA Under Secretary’s Award for Outstanding Achievement in Health Services Research. He hopes to use the financial support that comes with the award to establish a center at the VA where students, clinicians, policymakers and researchers can learn and expand their thinking about high-value care. We asked him about his work.

“There is clear science that demonstrates that a large portion of health care in the United States is unnecessary, ineffective or even harmful, and that it costs a lot of money.”
What motivates you to do this kind of research?
There is clear science that demonstrates that a large portion of health care in the United States is unnecessary, ineffective or even harmful, and that it costs a lot of money. There's also evidence that there's very effective health care that has acceptable harms and costs and is underutilized. I believe we have an important opportunity and obligation to deliver health care services that are high-value.

What do you mean by high-value care?
The highest quality health care provides benefits that clearly justify its harms and the costs.

There are two ways to provide it. One is to reduce the number of services that are known to be of low value. Reducing unnecessary treatments and the costs and harms associated with them allows us more space, as it were, for getting effective health care for those who need it. The other is to promote those interventions that may be of higher value.

What are examples of this kind of care?
One area that we know about is screening for breast, cervical and prostate cancer. For a long time, we have had a belief that higher-intensity screening—screening more people more frequently and with a test that looks harder and harder—was what was necessary. We'd say, “Find the cancer, treat it early, and it could save your life”—it did mine.” What we now know is that screening really is a two-edged sword. It can provide incredible personal and public benefits; but it also has harms. We can, however, find an optimal balance.

For breast cancer, the science shows that screening women beginning at age 50 or, if they strongly desire it, at age 40 every two years provides nearly identical benefit in reduction of breast cancer deaths with far fewer harms and lower costs than what we once did. For cervical cancer, we now know that screening women beginning at age 21 rather than earlier, and screening them every three years with the Pap smear, or beginning at age 30 every five years with the combination of the Pap test and the HPV test, and ending at age 65 for women who've had normal tests, provides the optimal balance of benefits and costs. Finally, we now know that prostate cancer screening—as it is currently practiced—is low-value care. At best, it results in a very small reduction in prostate cancer deaths, with no reduction in all-cause mortality over 10 to 15 years. Yet it results in considerable harms and has a high cost. Thus, recommending against a PSA blood test is a high-value and good health care choice.

Isn't it hard to convince clinicians, patients and organizations to change their thinking?
It’s both a difficult and an exciting and important challenge. We’ve begun to work on how to effectively communicate this to physicians and patients. Change is hard, but change is really important when the science tells us we need to change. We now have clear evidence that sometimes less health care is better health care.

We’re working on developing shared decision-making tools that effectively communicate information to patients, and allow them to incorporate their values in treatment decisions and more fully understand the trade-offs that are made between possible benefit and known harms.

You’ve done studies on so many different diseases and treatments. How can you work in so many areas?
I’m a generalist. That’s my personality. There are others who really like digging deep. I’m not saying I’m at the 40,000-foot view, but I look at things from a primary care generalist’s point of view and collaborate with very talented individuals possessing additional disease content or research methods expertise. I might not know the exact nuances of the biochemistry or all the physiology or exact methods of a surgical or radiation procedure. But I understand if those things are likely to be really important difference makers for patients, clinicians and policy makers.

You spend 20 percent of your time seeing patients. Why do you do that?
I’m a physician first. I think of my patients when I’m doing research. They’re not just kidney disease, they’re humans who have a variety of cares and concerns, and that really informs how I do my work.

Furthermore, the research that I do informs my clinical practice. For example, my study of prostate cancer has helped me more effectively counsel men about treatment options. Seeing patients keeps my research practical rather than strictly academic.

How can other practicing physicians access the evidence that researchers like you are providing?
They can turn to trustworthy sources of information, including the Choosing Wisely campaign. There are good summaries of information and good CME courses by groups that have low conflicts of interest and provide a balanced set of recommendations.

Some have called the evidenced-based medicine movement cookbook medicine. What’s your response to that?
Some critics say let’s have individual patient-centered medicine. But if you take that to the extreme, it’s silly. If you say everybody is completely unique, then you can’t do research on anything. Then any study you do is not applicable to the patient you see.

The clinical science that I and others provide is the evidence foundation on the benefits, harms and costs. We put that into guidelines, not prescriptive mandates. The idea is to help guide physicians and patients to the highest-quality care. The word “guideline” came from mountain guides. They would mark a route up a mountain. It’s not the only way up the mountain, but it’s probably the best and safest way. That’s what guidelines should be.
Yes, but that isn't always what happens, is it?
Sometimes guidelines get turned into performance measures and mandates. Sometimes physicians don't have the opportunity to digest fully what those guidelines say. Sometimes health care systems rigidly look at them without thinking them through. Physicians need to have more time to look at the considerations.

If there's one thing that discourages me about medicine, it's that we have some of the best and brightest minds in the world, but sometimes with all of the requirements to do so much with so little time, we destroy not only physicians' creativity but their ability to think critically and have healthy skepticism. Physicians need more time both to engage with their patients and to read and keep up with information. They should not just be box-clickers. I advocate for physicians having more time for patients and for learning.

Are we moving in the right direction in terms of providing more high-value and less low-value care?
Yes. The U of M now has a curriculum for medical residents in high-value, cost-conscious care and the American College of Physicians includes having knowledge about high-value cost-conscious care as part of the internal medicine accreditation process. It is now one of the key components of internal medicine training.

And there's a greater appreciation that screenings and treatments have harms as well as benefits and costs. With regard to prostate cancer, the American Urological Society and the American Cancer Society have adjusted their recommendations. No organization now recommends routine PSA testing. That's a marked change from 10 years ago.

Even with breast cancer and cervical cancer screening, there's been considerable change in terms of awareness about overdiagnosis and harms from screening and treatment. OB/GYN societies now agree that cervical cancer screening less intensively rather than more intensively is a better option. And women and patients now understand that less care can be better care. JAMA Internal Medicine runs a regular series titled “Less is more.”

This is not a movement to primarily save costs. It is driven by science that is informing us about what is good care for our patients as well as what is wise stewardship of our resources. That's good health care. That's improving the quality of care we deliver.

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